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# Aged care safety dilemma: caring-for-self versus caring-for-residents

Lynnaire Sheridan

*University of Wollongong*, [lynnaire@uow.edu.au](mailto:lynnaire@uow.edu.au)

Teslime Agim

*University of Wollongong*, [ta741@uowmail.edu.au](mailto:ta741@uowmail.edu.au)

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# Aged care safety dilemma: caring-for-self versus caring-for-residents

## Abstract

**Aim** To identify aged care specific work health and safety management issues by applying James Reason's safety culture theory to one residential aged care provider in Australia. **Methods** Qualitative, semi-structured interviews with frontline care staff at three residential care facilities - all operated by the same provider - garnered employee perceptions of the safety culture and aged care specific challenges in their work environment. Thematic analysis of participant responses against the premises of James Reason's safety culture theory was undertaken. **Results** An aged care safety dilemma exists for frontline staff between looking after their own safety, a fundamental premise in work health and safety management, and caring for residents. **Conclusions** A 'culture of care' and professional identity inhibit safe behaviour. Organisational learning from incidents could assist employees in putting their safety first in care scenarios. Evaluating perceived barriers to carer-first safety practices, such as understaffing or time pressures, may facilitate safer outcomes.

## Keywords

care, safety, aged, dilemma, versus, caring, self, residents

## Disciplines

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## ***The aged care safety dilemma: Caring-for-self versus caring-for-residents***

**Objective:** To identify age-care specific work health and safety management issues by applying James Reason's safety culture theory to one residential aged care provider in Australia.

**Method:** Qualitative, semi-structured interviews with frontline care staff at three residential care facilities - all operated by the same provider - garnered employee perceptions of the safety culture and aged-care specific challenges in their work environment. Thematic analysis of participant responses against the premises of James Reason's safety culture theory was undertaken.

**Results:** An aged care safety dilemma exists for frontline staff between looking after their own safety, a fundamental premise in work health and safety management, and caring for residents.

**Conclusions:** A 'culture of care' and professional identity inhibit safe behaviour. Organisational learning from incidents could assist employees in putting their safety first in care scenarios. Evaluating perceived barriers to carer-first safety practices, such as understaffing or time pressures, may facilitate safer outcomes.

**Keywords:** Homes for the Aged, Organisational Culture, Work Health and Safety

### **Key Points:**

- An age-care specific work health and safety dilemma is frontline staff prioritising residents' needs above their own wellbeing which is contrary to work health and safety legislation and aged care provider policy.
- Employee-perceived pressures including understaffing and/or insufficient time to undertake tasks appear to be workplace-driven. Employees' personal beliefs of what 'carer' means or concerns regarding negative resident perceptions of carers appear to be internal motivators for participating in high risk activities that could incur injury.
- Aged care providers will require sector-specific strategies to address these cultural elements of work health and safety management to enhance the outcomes of their established formal hazard-focused training programs.

## INTRODUCTION

In 2012, one Australian residential aged care provider participated in research investigating employee engagement in work health and safety practices via the application of James Reason's Safety Culture Theory [1,2]. Reason proposes that tangible elements of a work health and safety system, such as incident reporting (reporting culture) and safety training (learning culture), might be considered alongside intangibles, such as the moral-ethical values of the workplace (just culture) and the ability of the organisation to empower workers to initiate responses to hazard management (flexible culture).[1,2] Frontline care staff perspectives on these cultural facets were sought to determine if Reason's ideal safety culture was achieved.

This research brief focuses on emergent findings specific to aged care work health and safety management. This industry was selected as it is high risk for injury [3] and the sector's high growth rate may see higher numbers of workers injured if there is not reliable research to improve work health and safety.[4]

## METHOD

Qualitative, semi-structured interviews were undertaken at three residential care sites to provide a snapshot of employee perspectives on safety culture within and across sites operated by the same aged care provider. Site visits took place on three separate days in September 2012. Interviews were conducted with as many frontline care staff as possible on the day at each site. The interview questions specifically targeted the reporting, learning, just and flexible culture facets of the theory. After providing verbal consent, participants were encouraged to offer examples or anecdotes from their workplace. Any identifying information was removed from the data before the transcripts were uploaded into N-Vivo software. Interviews were thematically coded against the four aspects of Reason's safety culture before free nodding of recurring sector-specific issues was undertaken.

## FINDINGS

Twenty six people participated; ten from Site One, eight from Site Two and another eight from Site Three. Each participant is allocated a code; 'S#' refers to the site and 'P#' represents an individual participant.

Data from all sites highlighted a moral conflict in aged care frontline staff between protecting their own safety and providing care to aged residents. Scenarios where patients, at risk of injury, required a care-giver's response which might affect the latter's personal wellbeing occurred daily. Participants mentioned staff or time limits associated with lifting a resident due to their immediate need to toilet, shower or eat. While some people were able to prioritise their own safety, despite client complaints, and wait for another staff member, others felt guilty and conflicted over not providing care to their resident even if it meant lifting someone on their own and putting themselves at risk.

Half (thirteen) participants felt that employee safety came before resident safety. Many who prioritised their safety took a long-term perspective: *"If you do not work safe, you cannot look after yourself or resident in need of care. You need to think - my safety first - then resident safety"* (S3, P3). Other employees were pragmatic and felt that their own wellbeing was innately valuable and important to protect: *"You have to ensure that you are safe and you should always think of your own safety before actioning your next step. If this means you look after yourself before the resident, you must look after yourself"* (S2, P4). Some participants prioritised their safety because it was the policy of the aged care provider: *"[The organisation's] ambition is that safety works with care. Employees make both work together"* (S3, P6).

Of the other participants, thirteen perceived that work-related conditions, namely a lack of staff and time, meant that resident safety was organisationally prioritised over their personal safety: *"A lack of staff puts everyone's safety at risk, the resident and employees too"* (S3, P8). One risk scenario provided was: *"A lack of staff is a problem when more than one person is required to do something, like lifting patients. The employee has no choice but to lift the resident"* (S3, P3). Likewise, when there was limited time to complete tasks: *"Time constraints provoke decisions and some staff members attempt things on their own, such as lifting even though it can be a safety risk to them and the residents"* (S1, P6).

Some staff stated that resident perceptions of them created pressures which contributed to poor safety practice: *"When employees go to do paperwork [reporting], residents think that we are ignoring them"* (S3, P7) and *"Residents insist that you work around their obligations. They do not understand that more goes on than the short interactions you have with them daily"* (S2, P3).

However, consideration of the theory across the organisation did present some strategies to combat poor work health and safety practices among carers. A poor safety feedback loop was identified in analysis of reporting and learning cultures. Reduced staff perceptions of risk may occur if incident outcomes are not readily communicated: *"To lessen accidents from happening, more education is needed based on previous accidents to help prevent [the] same accidents happening in the future"* (S3, P3). It is suggested that increased learning from the outcomes of patient-first safety decisions and their negative consequences to peers may be one way of increasing broader understanding of why the carer should put themselves first in all care scenarios, thus reducing non-compliance with policy.

Poor communication of incident outcomes reduced staff motivation with some then 'hiding' incidents to avoid the work of reporting them because it did not appear to lead to any noticeable change: *"Although your contribution is listened to, when there is no action on it, you think to yourself: 'why am I trying to help them if they won't help me?' It starts with not reporting accidents, to hiding the truth and so forth."* (S1, P8). While understaffing and time pressures in aged care may present an increased risk to the safety of staff and care for residents, employees putting patients first rather than waiting for assistance with a high-risk activity may reduce the aged care provider's awareness of the consequences of the current staffing situation and inhibit the development of a sustainable, safe, long-term solution. 'Hiding' incidents by not following procedures could de-rail the organisation's mechanisms for solving potential safety issues. How might an organisation be expected to know about the real consequences of current employee numbers if staff 'carry on as usual' without consideration for their personal safety?

Notably, strategies to combat resident perception of care and personal expectations of employees of what it is to be a 'carer' were less forthcoming.

## CONCLUSIONS

Aged care sector specific issues did emerge in this study. Half the participants were work health and safety compliant and put their safety first. However, half ignored policy and prioritised aged care residents influenced by perceived low staff numbers, time constraints and resident expectations of 'care'. Reason's ideal safety culture therefore was not achieved in this organisation. Research on other patient care contexts has found that carers who put themselves first do reduce the occurrence of incidents and thus allow all employees to do their work properly. [4] In an aged care setting, employee safety must still be paramount and a fundamental basis of compliance with work health and safety solutions must be identified.

Primarily, this study found that communication with staff about procedural changes and/or learnings resulting from incidents might increase with perceptions of hazards and subsequent compliance with work health and safety policy. Secondly, while understaffing in aged care can present an increased risk to the safety of employees and residents, employees putting patients first may inhibit the development of a sustainable, safe, long-term solution. It is proposed that creating a just culture, where employees are free to report incidents and actively seek safe work options without reprimand, would support the development of innovative solutions. Furthermore, a flexible culture might stimulate frontline staff to create the solutions.

Finally, the most difficult challenge emerging from the data is how to ensure compliance when the individual perceives a conflict between their identity as a 'carer' and their personal safety. The nature of being a carer, with the associated professional identity, does appear to make some employees vulnerable to resident perceptions of what care is and how caring they are, thus encouraging them to put the safety of residents before their own. What is identified here is that, in some cases, there does appear to be a 'culture of care' acting against organisational policy. Further research into the impact of these perceptions on individual safety-related decision-making would make a useful contribution to the aged care sector.

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